FAIRFIELD DERMATOLOGY

PATIENT REGISTRATION FORM

Name: _____ Social Security #_____

Address: _____

Date of birth: _____/_____/_____

Check Preferred Contact Phone Number

Cell Phone: _____ ☐ Home Phone: _____ ☐

Email Address: _____

IF YOU WOULD LIKE PARENTS, CHILDREN, OR CAREGIVERS TO HAVE ACCESS TO YOUR MEDICAL RECORDS:

I agree that the following people may have access to my complete medical record. I may rescind this in writing at any time.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Social Security #_____

Address (if different from patient):_____

Date of birth: _____/_____/_____ Relationship to Patient: _____

Referred By: _____ Primary Care Physician: _____

Signature: _____ **Date: _____**